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UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

UNITED STATES OF AMERICA, Plaintiff, v. JOSEPH CAMPBELL, Defendant.	No. **COMPLAINT**

The United States of America, by Christopher J. Christie, United States Attorney for the District of New Jersey, for its Complaint states:

OVERVIEW

1. This is an action brought by the United States to recover damages and civil penalties under the False Claims Act ("FCA"), and to recover all available damages for common law fraud, unjust enrichment, payment by mistake and disgorgement. These claims are premised upon Defendant's prohibited financial relationship with the University of Medicine and Dentistry in Newark, New Jersey ("UMDNJ"). Defendant violated 31 U.S.C. §§ 3729-33 and Section 1877 of the Social Security Act, codified at 42 U.S.C. § 1395nn and commonly referred to as the

"Stark Statute," by referring Medicare patients to UMDNJ's University Hospital ("UH"), an entity with which he had a financial relationship. Defendant then caused to be submitted false claims – based on the prohibited financial relationship – to the Medicare and Medicaid Program in violation of the FCA.

JURISDICTION

2. This Court has jurisdiction over this action pursuant to 28 U.S.C. §§ 1345 & 1331. Defendant resides within and/or is doing and/or previously did business within this District.

VENUE

3. Venue is proper in this District pursuant to 28 U.S.C. § 1391 and 31 U.S.C. § 3732(a). Defendant resides within and/or is doing and/or previously did business within this District.

PARTIES

4. The United States brings this lawsuit on behalf of its Department of Health and Human Services (HHS).

5. Defendant Joseph Campbell is a medical doctor licensed to practice in the State of New Jersey, who resides in Orange, New Jersey. Defendant has a private medical practice specializing in cardiology, with an office in Irvington, New Jersey. From in or about January 2003 to in or about December 2003, Defendant served as a Clinical Assistant Professor at UMDNJ.

BACKGROUND

THE LAW

A. The False Claims Act

6. The FCA provides, in pertinent part that:

> (a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; . . . or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,
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> * * *
>
> is liable to the United States Government . . . .
>
> (b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

31 U.S.C. § 3729.

B. The Stark Statute

7. The Stark Statute prohibits a physician from referring Medicare patients for certain "designated health services" (DHS) to an entity with which he has a "financial relationship," unless an exception applies. When originally enacted in 1989 ("Stark I"), the prohibitions applied only to physicians' referrals for clinical laboratories. Omnibus Budget Reconciliation Act of 1989, P.L. 101-239, § 6204. In 1993, Congress extended the Stark Statute

to referrals for ten additional DHS, including inpatient and outpatient hospital services (Stark II). *See* Omnibus Reconciliation Act of 1993, P.L. 103-66, § 13562, Social Security Act Amendments of 1994, P.L. 103-432, § 152.

8. In addition to prohibiting certain physician referrals, the Stark Statute prohibits health care entities from presenting or causing to be presented any Medicare claim for DHS provided as a result of a prohibited referral. 42 U.S.C. § 1395(a)(1)(B). Any entity that collects Medicare payment for DHS rendered pursuant to a prohibited referral must refund all collected amounts. 52 U.S.C. § 1395nn(g)(2); 42 C.F.R. § 411.353(d).

9. Under the Stark Statute, the United States will not pay for certain items or services prescribed or ordered by physicians who have improper financial relationships with the entities that furnish those items or services. One of the major purposes of the statute was to reduce losses suffered by the Medicare program due to overutilization of services.

10. The Stark Statute broadly defines "financial relationship" to include ownership and investment interest and compensation agreements that involve any direct or indirect remuneration between a physician and an entity providing DHS. The statute's exceptions identify specific types of investments and compensation agreements that will not violate its referral and billing prohibitions.

11. For example, compensation paid to a referring physician serving as an employee in a hospital will fall within an exception to the statute if: (1) the employment is for readily identifiable services; (2) the amount of remuneration paid to the physician is consistent with the fair market value of the services provided and is not “determined in a manner that takes into account directly or indirectly the volume or value of any referrals” by the physician; and (3) the

compensation to the physician would be commercially reasonable" in the absence of any referrals by the physician. 42 U.S.C. § 1395nn(e)(2). Thus, compensation paid to a physician under an employment agreement that exceeds fair market value, for which no actual services are performed, or which takes into account the volume or value of the referrals or other business generated between the parties, triggers the referral and payment prohibitions of Stark II with respect to designated health services referred by that physician.

12. Violation of the statute may subject the physician to exclusion from participation in federal health care programs and various financial penalties, including (a) a civil money penalty of $15,000 for each service included in a claim for which the physician knew or should have known that payment should not be made under Section 1395nn(g)(1); and (b) an assessment of three times the amount claimed for a service rendered pursuant to a referral the physician knew or should have known was prohibited. *See* 42 U.S.C. §§ 1395nn(g)(3), 1320a-7a(a).

UMDNJ

13. At all times relevant to this Complaint:

a. UMDNJ was the State of New Jersey's university of health sciences and consisted of eight separate schools, including the UMDNJ-New Jersey Medical School ("NJMS"). UMDNJ also owned and operated UMDNJ-University Hospital ("UH").

b. NJMS was located in Newark, New Jersey, and provided instruction in the practice of medicine, performed medical research and delivered patient care through affiliated hospitals. NJMS had an accredited cardiology fellowship program.

c. UH was a teaching hospital in Newark, New Jersey, with medical students, residents and fellows (including those of NJMS's cardiology fellowship program) rendering

medical care to UH's patients.

d. UH was also a Level I Trauma Center licensed and regulated by the State of New Jersey. Among other things, UH's license with the State of New Jersey was dependent on UH's annual performance of a certain number of cardiac procedures, including cardiac catheterizations and cardiothoracic surgery, described more fully herein.

14. At all times relevant to this Complaint

a. Medicare was a federal health care benefit program established by the Social Security Act of 1965, codified, as amended, in Title 42 of the United States Code (the "Medicare program"). The Medicare program provided basic health insurance coverage to individuals over the age of 65 and to certain persons entitled to Social Security benefits based upon disability.

b. UMDNJ participated in the Medicare program and submitted claims to Medicare (through its fiscal intermediary) for services UH rendered to Medicare beneficiaries. From at least 2003 through at least 2006, UMDNJ received money from the Medicare program for services UH rendered to Medicare beneficiaries.

15. At all times relevant to this Complaint:

a. "Cardiology" was a branch of medicine that dealt with the diagnosis and treatment of heart disease.

b. A "cardiac catheterization" was a medical procedure whereby a qualified cardiologist would place a catheter or thin plastic tube into the artery or vein of a patient's arm or leg and then advance it to the patient's heart or coronary arteries in order to diagnose problems with the heart or perform interventional procedures, such as angioplasties.

c. "Cardiothoracic surgery", commonly referred to as "open heart surgery", was a

medical procedure whereby a qualified cardiologist would physically open the chest wall of a patient to expose the heart muscle and, thus, allow for a variety of corrective procedures to be performed, such as coronary artery bypass surgeries, valve replacements and heart transplants.

UMDNJ'S CLINICAL ASSISTANT PROFESSOR PROGRAM

16. Since at least 1995, and in each year relevant to this Complaint, UH failed to perform the requisite number of cardiac procedures to satisfy its licensing requirements as a Level I Trauma Center in the State of New Jersey.

17. In an effort to increase the number of cardiothoracic patients that were referred to UH, and thus avoid losing UH's accreditation as a Level I Trauma Center, in or about Spring 2002, UMDNJ and certain of its administrators undertook a community cardiology/cardiac surgery initiative. Pursuant to that initiative, UMDNJ entered into part-time employment contracts with a number of community cardiologists who had their own private cardiology practices and significant numbers of patients they could refer to UH.

18. The contracts purportedly required the community cardiologists to work part-time at UH as Clinical Assistant Professors, performing bona fide services for UMDNJ, such as teaching NJMS's cardiology fellows in the catheterization lab, providing on-call coverage, attending weekly cardiology conferences, lecturing, and supporting UMDNJ's research efforts.

19. The employment contracts provided that the community cardiologists would receive annual salaries of between approximately $50,000 and approximately $180,000, purportedly as consideration for their performance of the duties specified in the contracts.

CAMPBELL'S PROHIBITED REFERRALS

20. In or about January 2003, Defendant entered into an employment contract with UMDNJ to serve as a faculty cardiologist in the Clinical Assistant Professor program.

21. Defendant had a private cardiology practice with patients to refer to UH for cardiac-related procedures.

22. The employment contract provided, in substance and in part, that Defendant would serve as a Clinical Assistant Professor, would be paid an annual salary of approximately $75,000, and would commit 48% of his time (i.e., almost 20 hours a week) performing the following teaching, research and patient care activities at UMDNJ:

a. teaching fellows at cardiac catheterization procedures;

b. interpreting hospital electrocardiograms;

c. attending weekly cardiology conferences;

d. conducting a physical diagnosis course for second year medical students;

e. providing office-based teaching;

f. lecturing in areas of special expertise;

g. supporting research efforts; and

h. completing Medicare time studies and other forms to document the services provided under the contract to ensure appropriate Medicare payments were made to UH.

23. From in or about January 2003 to in or about December 2003, Defendant knowingly and willfully failed to perform most, if not all, of the bona fide services enumerated under the employment contract. The primary service he performed for UMDNJ was to refer patients from his private cardiology practice to UH for cardiac-related procedures, many of which

were paid for by Medicare.

24. From in or about January 2003 to in or about December 2003, Medicare paid more than $55,000 for cardiac-related procedures that were performed at UH on more than 7 patients referred from Defendant's private cardiology practice.

25. At the same time, Defendant obtained payments from UMDNJ totalling approximately $70,000.

The Medicare and Medicaid Programs

26. In 1965, Congress enacted Title XVIII of the Social Security Act, known as the Medicare program, to pay for the costs of certain healthcare services. Entitlement to Medicare is based on age, disability or affliction with end-stage renal disease. *See* 42 U.S.C. §§ 426, 426A. Part A of the Medicare Program authorizes payment for institutional care, including hospital, skilled nursing facility and home health care. *See* 42 U.S.C. §§ 1395c-1395i-4.

27. HHS is responsible for the administration and supervision of the Medicare program. The Centers for Medicare and Medicaid Services (CMS) is an agency of HHS and is directly responsible for the administration of the Medicare program.

28. Under the Medicare program, CMS makes payments retrospectively (after the services are rendered) to hospitals for inpatient and outpatient services. Medicare enters into provider agreements with hospitals in order to establish the hospitals' eligibility to participate in the Medicare program. However, Medicare does not prospectively contract with hospitals to provide particular services for particular patients. Any benefits derived from those services are derived solely by the patients and not by Medicare or the United States.

29. Defendant submitted or caused to be submitted claims both for specific services

provided to individual beneficiaries and claims for general and administrative costs incurred in treating Medicare beneficiaries.

30. To assist in the administration of Medicare Part A, CMS contracts with "fiscal intermediaries." 42 U.S.C. § 1395h. Fiscal intermediaries, typically insurance companies, are responsible for processing and paying claims and cost reports.

31. Upon discharge of Medicare beneficiaries from a hospital, the hospital submits claims for interim reimbursement for items and services delivered to those beneficiaries during their hospital stays. 42 C.F.R. §§ 413.1, 413.60, 413.64. Hospitals submit patient-specific claims for interim payments on a Form UB-92.

32. As a prerequisite to payment by Medicare, CMS requires hospitals to submit annually a form CMS-2552, more commonly known as the hospital cost report. Cost reports are the final claim that a provider submits to the fiscal intermediary for items and services rendered to Medicare beneficiaries.

33. After the end of each hospital's fiscal year, the hospital files its hospital cost report with the fiscal intermediary, stating the amount of reimbursement the provider believes it is due for the year. *See* 42 U.S.C. § 1395g(a); 42 C.F.R. § 413.20. *See also* 42 C.F.R. § 405.1801(b)(1). Hence, Medicare relies upon the hospital cost report to determine whether the provider is entitled to more reimbursement than already received through interim payments, or whether the provider has been overpaid and must reimburse Medicare. 42 C.F.R. §§ 405.1803, 413.60 and 413.64(f)(1).

34. UMDNJ was, at all times relevant to this Complaint, required to submit annually a hospital cost report to the fiscal intermediary.

35. During the relevant time period, Medicare payments for hospital services were determined by the claims submitted by the provider for particular patient discharges (specifically listed on UB-92s) during the course of the fiscal year. On the hospital cost report, this Medicare liability for services is then totaled with any other Medicare liabilities to the provider. This total determines Medicare's true liability for services rendered to Medicare beneficiaries during the course of a fiscal year. From this sum, the payments made to the provider during the year are subtracted to determine the amount due the Medicare program or the amount due the provider.

36. Under the rules applicable at all times relevant to this Complaint, Medicare, through its fiscal intermediaries, had the right to audit the hospital cost reports and financial representations made by UMDNJ to ensure their accuracy and preserve the integrity of the Medicare Trust Funds. This right includes the right to make retroactive adjustments to hospital cost reports previously submitted by a provider if any overpayments have been made. 42 C.F.R. § 413.64(f).

37. Every hospital cost report contains a "Certification" that must be signed by the chief administrator of the provider or a responsible designee of the administrator.

38. At all times relevant to this Complaint, the hospital cost report certification page included the following notice:

> Misrepresentation or falsification of any information contained in this cost report may be punishable by criminal, civil and administrative action, fine and/or imprisonment under federal law. Furthermore, if services identified in this report were provided or procured through the payment directly or indirectly of a kickback or where otherwise illegal, criminal, civil and administrative action, fines and/or imprisonment may result.

39. At all times relevant to this Complaint, the responsible provider official was

required to certify, in pertinent part:

> to the best of my knowledge and belief, it [the hospital cost report] is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.
>
> I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

40. Thus, the provider was required to certify that the filed hospital cost report is (1) truthful, *i.e.*, that the cost information contained in the report is true and accurate; (2) correct, *i.e.*, that the provider is entitled to reimbursement for the reported costs in accordance with applicable instructions; (3) complete, *i.e.*, that the hospital cost report is based upon all information known to the provider; and (4) that the services provided in the cost report were billed in compliance with the Stark Statute.

41. A hospital is required to disclose all known errors and omissions in its claims for Medicare reimbursement (including its cost reports) to its fiscal intermediary. 42 U.S.C. § 1320a-7b(a)(3) specifically creates a duty to disclose known errors in cost reports:

> Whoever . . . having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment . . . conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized . . . shall in the case of such a . . . concealment or failure . . . be guilty of a felony.

42. UMDNJ submitted cost reports, with the signed certification quoted above, at all times material to this Complaint. Defendant, in violating the Stark Statute by referring patients to UH, an entity with which he had a financial relationship, caused the certification quoted above

to be falsely submitted.

43. Medicaid is a joint federal-state program that provides health care benefits for certain groups, primarily the poor and disabled. The federal involvement in Medicaid is largely limited to providing matching funds and ensuring that states comply with minimum standards in the administration of the program.

44. The federal Medicaid statute sets forth the minimum requirements for state Medicaid programs to qualify for federal funding, which is called federal financial participation (FFP). 42 U.S.C. §§ 1396 *et seq*.

45. Each state's Medicaid program must cover hospital services. 42 U.S.C. § 1396a(10)(A), 42 U.S.C. § 1396d(a)(1)-(2).

46. In New Jersey, provider hospitals participating in the Medicaid program submit claims for hospital services rendered to beneficiaries to the New Jersey Department of Human Services.

False and Fraudulent Claims and Statements

47. Defendant, who entered into a prohibited financial relationship with UH, referred patients, including Medicare and Medicaid patients, to UH in violation of federal law. Defendant in turn, caused claims to be submitted to Medicare and Medicaid by UH and payments to be made by the United States. Under the False Claims Act, 31 U.S.C. § 3729(a)(1), such claims were false and/or fraudulent because UMDNJ had no entitlement to payment for services provided on referrals from Defendant.

48. Defendant also violated the False Claims Act, 31 U.S.C. § 3729(a)(2), by causing to be made false statements when these claims were submitted for payment to Medicare and

other government programs. Defendant caused the claims and statements to be falsely certified "true" and/or "correct."

49. Defendant also caused false certifications, in violation of the False Claims Act, 31 U.S.C. § 3729(a)(7), that the services identified in UH's annual cost reports were provided in compliance with federal law, including the prohibitions on improper financial relationships with physicians.

50. Defendant caused to be submitted false claims to Medicare and Medicaid for payment including claims submitted for Medicare payment in violation of Stark II, 42 U.S.C. § 1395nn(a)(2).

51. Defendant caused to be submitted false cost reports to Medicare for the year 2003 with supporting documents and certifications knowing that those documents included false representations. Each cost report included a certification falsely representing that services provided by the hospital were provided in compliance with pertinent laws and regulations when in fact, Defendant knew that he had violated various laws and regulations, including those pertaining to prohibited financial relationships.

Amount of Medicare and Medicaid Payments

52. As a result of the false and fraudulent claims which Defendant caused to be submitted for reimbursement, Medicare reimbursed UMDNJ at least $55,504 in Medicare monies during 2003; and at least $21,314 in Medicaid monies during 2003.

53. In so doing, Defendant caused to be presented these claims with actual knowledge of their falsity, or in deliberate ignorance or reckless disregard that such claims were false and fraudulent.

Count I
False Claims Act, 31 U.S.C. § 3729(a)(1)
Presenting Claims to Medicare and Medicaid
for Services Rendered as a Result of a Prohibited Financial Relationship

54. Plaintiff incorporates by reference paragraphs 1-53 of this Complaint as if fully set forth.

55. Defendant knowingly caused to be presented, false and fraudulent claims for payment or approval to the United States, including claims for reimbursement for services rendered to patients Defendant unlawfully referred to UMDNJ, with whom Defendant entered into a prohibited financial relationship in violation of the Stark Statute.

56. By virtue of the false or fraudulent claims caused to be made by Defendant, the United States suffered damages and therefore is entitled to multiple damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,500 to $11,000 for each violation.

Count II
False Claims Act, 31 U.S.C. § 3729(a)(2)
Use of False Statements

57. Plaintiff incorporates by reference paragraphs 1-56 of this Complaint as if fully set forth.

58. Defendant knowingly caused to be made or used, false records or statements — *i.e.,* the false certifications and representations caused to be made by Defendant when the false claims for interim payments were initially submitted and the false certifications caused to be made by Defendant when the cost reports were submitted — to get false or fraudulent claims paid and approved by the United States.

59. By virtue of the false or fraudulent claims caused to be made by Defendant, the

United States suffered damages and therefore is entitled to multiple damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,500 to $11,000 for each violation.

Count III
False Claims Act, 31 U.S.C. § 3729(a)(7)
False Record to Avoid an Obligation to Refund

60. Plaintiff incorporates by reference paragraphs 1-59 of this Complaint as if fully set forth.

61. Defendant knowingly caused to be made or used false records or false statements — *i.e.*, the false certifications caused to be made by Defendant when the cost reports were submitted — to conceal, avoid, or decrease an obligation to pay or transmit money or property to the United States.

62. By virtue of the false records or false statements caused to be made by Defendant, the United States suffered damages and therefore is entitled to treble damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,500 to $11,000 for each violation.

Count IV
Common Law Fraud

63. Plaintiff incorporates by reference paragraphs 1-62 of this Complaint as if fully set forth.

64. Defendant caused to be made material and false representations in UMDNJ's cost reports with knowledge of their falsity or reckless disregard for their truth, with the intention that the United States act upon the misrepresentations to its detriment. The United States acted in justifiable reliance upon misrepresentations caused to be made by Defendant by making interim payments on the false claims and then by settling the cost reports at inflated amounts.

65. Had the true facts been known to the United States, the United States would not have made the interim payments or the inflated amounts on the cost reports.

66. By reason of these interim payments and the inflated amounts on the cost reports, the United States has been damaged in an amount to be determined at trial.

Count V
Unjust Enrichment

67. Plaintiff incorporates by reference paragraphs 1-66 of this Complaint as if fully set forth.

68. This is a claim for the recovery of monies by which Defendant has been unjustly enriched.

69. By directly or indirectly obtaining government funds to which he was not entitled, Defendant was unjustly enriched, and is liable to account and pay such amounts, or the proceeds therefrom, which are to be determined at trial, to the United States.

Count VI
Disgorgement

70. Plaintiff incorporates by reference paragraphs 1-69 of this Complaint as if fully set forth.

71. This is a claim for disgorgement of profits earned by Defendant because of a prohibited financial relationship.

72. Defendant concealed his prohibited activity through false statements, claims, and records, and failed to abide by his duty to disclose such information to the United States.

73. The United States did not detect Defendant's prohibited conduct.

74. This court has the equitable power to, among other things, order Defendant to disgorge the entire profit Defendant earned from business generated as a result of his violations of the Stark Statute, state laws and the False Claims Act.

Count VII
Payment Under Mistake of Fact

75. Plaintiff incorporates by reference paragraphs 1-74 of this Complaint as if fully set forth.

76. This is a recovery of monies paid by the United States as a result of mistaken understandings of fact.

77. The false claims which Defendant caused to be submitted to the United States were paid by the United States based upon mistaken or erroneous understandings of material fact.

78. The United States, acting in reasonable reliance on the truthfulness of the claims and the truthfulness of the certifications and representations caused by Defendant, paid certain sums of money, to which Defendant was not entitled, and Defendant is thus liable to account and pay such amounts, which are determined at trial, to the United States.

Prayer For Relief

WHEREFORE, Plaintiff, United States requests that judgment be entered in its favor and against Defendant jointly and severally as follows:

1. On the First, Second, and Third Counts under the False Claims Act for the amount of the United States' damages, trebled as required by law, and such civil penalties as are required by law, together with all such further relief as may be just and proper.

2. On the Fifth and Seventh Counts for unjust enrichment and payment by mistake,

for the damages sustained and/or amounts by which Defendant was unjustly enriched or by which Defendant retained illegally obtained monies, plus interest, costs, and expenses, and all such further relief as may be just and proper.

3. On the Fourth Count, for common law fraud, for compensatory and punitive damages in an amount to be determined, together with costs and interest, and for all such further relief as may be just and proper.

4. On the Sixth Count, for disgorgement of illegal profits, for the disgorgement of the illegal profits obtained by Defendant and such further equitable relief as may be just and proper.

Dated: April 22, 2008

Respectfully submitted,

CHRISTOPHER J. CHRISTIE
United States Attorney

By:
ALEX KRIEGSMAN
Assistant United States Attorney